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Adult Intake Form

Please complete this form in legible handwriting and bring it to your first session.
The information you provide is protected as confidential information.

Name: _____ Preferred Name: _____
(First) (Middle Initial) (Last)

Address: _____
(Street and Number)

_____ (City) (State) (Zip)

Home Phone: _____ May I leave a message? Yes No

Cell/Other Phone: _____ May I leave a message and/or text? Yes No

Birth Date: _____ / _____ / _____ Age: _____

Gender Identity: Male Female Other: _____ Decline to State

Sexual Orientation: Heterosexual Gay Bisexual Other: _____ Decline to State

Racial/Ethnic Identity: _____ Decline to State

Language Preference: _____

Religious/Spiritual Beliefs: _____ Not Applicable

Education: some high school high school diploma some college college graduate

postgraduate

Marital Status:

Married Divorced Never Married Separated Domestic Partnership Widowed

Please list any children and ages: _____

Briefly, what is the main concern for which you are seeking my assistance? (i.e., depression, anxiety, relationship, stress, parenting, etc.)

Have you previously been in counseling before?

No Yes

If so, with whom? Was it helpful? Why or why not?

HEALTH AND SOCIAL INFORMATION:

1. How is your physical health at present?

Very Good Good Satisfactory Unsatisfactory Poor

Please list any specific health problems you are currently experiencing:

Please list any known allergies: _____

Name of Primary Care Physician: _____ Phone Number: _____

Would you like for me to be in contact with him/her regarding our sessions?

Not necessary at this time Yes

2. Are you currently taking any prescription ***non-psychiatric*** medication?

No Yes, please list: _____

Name of Prescribing Dr: _____ Phone Number: _____

3. Are you currently taking any prescription ***psychiatric*** medication?

No Yes, please list with dates prescribed: _____

Please list all previously prescribed ***psychiatric*** medication with dates: _____

Name of Prescribing Dr: _____ Phone Number: _____

Would you like for me to be in contact with him/her regarding our sessions?

Not necessary at this time Yes

Have you been assigned a formal mental health diagnosis? Please list: _____

4. How would you rate your current sleeping habits?

Very Good Good Satisfactory Unsatisfactory Poor

Please list any specific sleep problems you are currently experiencing:

5. How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

6. Please list any difficulties you experience with your appetite or eating patterns:

7. Are you currently experiencing overwhelming sadness, grief or depression?

No Yes, for approximately how long? _____

Check ALL applicable symptoms:

<input type="checkbox"/> sadness more days than not	<input type="checkbox"/> weight loss or weight gain	<input type="checkbox"/> poor concentration
<input type="checkbox"/> lethargy/feeling tired	<input type="checkbox"/> increased or decreased appetite	<input type="checkbox"/> crying
<input type="checkbox"/> unmotivated	<input type="checkbox"/> insomnia or hypersomnia	<input type="checkbox"/> guilty or hopeless
<input type="checkbox"/> loss of interest in activities	<input type="checkbox"/> irritability/mood swings	<input type="checkbox"/> suicidality

8. Are you currently experiencing anxiety, panic attacks or have any phobias?

No Yes, when did you begin experiencing this? _____

Check ALL applicable symptoms:

<input type="checkbox"/> ruminating thoughts	<input type="checkbox"/> irritability/restlessness	<input type="checkbox"/> difficulty sleeping
<input type="checkbox"/> difficulty concentrating	<input type="checkbox"/> difficulty making decisions	<input type="checkbox"/> excessive worry
<input type="checkbox"/> sweating, trembling	<input type="checkbox"/> upset stomach/diarrhea	<input type="checkbox"/> headaches

9. Are you currently experiencing any chronic pain?

No Yes, please describe? _____

10. Are you currently thinking about hurting yourself? No Yes, by what means? _____

11. Have you ever thought about hurting yourself? No Yes, dates: _____

12. Have you ever tried to commit suicide? No Yes, dates: _____

13. Have you ever self-harmed via cutting, etc.? No Yes, dates: _____

14. Have you ever been hospitalized for psychiatric reasons? No Yes, dates: _____

15. Do you drink alcohol? No Yes, how many drinks per week? _____

16. Do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

Types: marijuana nicotine heroin/cocaine inhalants

hallucinogens (LSD, mushrooms) tranquilizers/sedatives (Xanax, sleeping pills)

stimulants (ecstasy, methamphetamine, cocaine)

17. Have you ever participated in a substance abuse program? No Yes, dates: _____

18. Would you like to address any substance use concerns in therapy? No Yes

19. Are you currently in a romantic relationship? No Yes, for how long? _____

On a scale of 1-10 (10 being the best), how would you rate your relationship overall? _____

On a scale of 1-10 (10 being the best), how would you rate your physical intimacy? _____

On a scale of 1-10 (10 being the best), how would you rate your emotional intimacy? _____

Do you wonder if you or your partner may be overly focused on sex or pornography? No Yes

20. Please list the names and relationships of those you consider to be a support to you:

21. What significant life changes or stressful events have you experienced recently?

FAMILY HISTORY:

Please answer the following regarding your family of origin (ie. your parents and siblings)

My parents are married divorced deceased, who & when? _____

My siblings names and ages are: _____

My family is intact estranged intact and estranged depending on the family members

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandfather, aunt, etc.).

<u>Diagnosis</u>		<u>List Family Member(s)</u>
Alcohol/Substance Abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Anxiety	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Domestic Violence	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Eating Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Obesity	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Obsessive Compulsive Behavior	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Schizophrenia	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Suicide Attempts	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? No Yes

If yes, what is your current employment situation?

2. Do you enjoy your work? Is there anything stressful about your current work?

3. Are you currently experiencing any legal issues? (ie. divorce, DUI, etc.) Please explain:

4. What do you consider to be some of your strengths?

5. What are some effective coping strategies that have worked for you?

6. What are some negative coping strategies you engage in?

7. What are some of your goals for therapy?

Thank you for taking the time to fill out this questionnaire. ~Rebecca Toner, LMFT